

Title	P12 Patient Safety Incident Response Policy (PSIRF)
Directorate	Clinical Quality & Governance
Policy Author	Hannah Graham, Chief Medical Officer
Policy Owner	Hannah Graham, Chief Medical Officer
Policy Developed in Consultation with: (name and title)	
Is this policy new or revised?	Revised
Document Number (if applicable):	Version Number (if applicable): 2.1

Original Publication Date	January 2024
Original Executive Owner	Chief Medical Officer

PRG Approval Date	August 2026
Next Review Date	August 2029 [At most 3 years from approval date]

Version Control

#	Date	Action	Comment	Reviewed by
V1	January 2024	Replaced the S6 Serious Incident and Concerns Policy	Replaced the S6 Serious Incident and Concerns Policy	PRG
V2	March 2026	Reviewed and revised	Revised to reflect current processes	Racheal Dix, Hannah Graham, PRG
V2.1	July 2026	Updated to incorporate ICB comments	Updated to incorporate ICB comments	Hannah Graham, ICB, PRG

This document is uncontrolled when printed

Contents

1. Introduction	3
2. Scope	3
3. Oversight roles and responsibilities	5
4. Patient Safety Partners	7
5. Addressing Health Inequalities	7
6. Our Approach to Incident Reporting and Learning	8
7. Engaging and Involving Patients, Families and Colleagues Following a Patient Safety Incident	9
7.1 Patients, Families and Carers	9
7.2 Communicating the Purpose of Patient Safety Investigations	9
7.3 Colleague Involvement & Support	9
7.4 Measuring the impact of a positive patient safety culture.....	9.
8. Patient Safety Incident Response Plan (PSIRP).....	11
9. Resources and Training.....	11
10. Our Patient Safety Incident Response Plan (PSIRP).....	12
10.1 Review of our Patient Safety Incident Response Policy & Plan.....	12
11. Responding to Patient Safety Incidents.....	12
11.1 Patient Safety Incident Reporting Arrangements	12
11.2 Patient Safety Incident Response Decision-Making.....	12
11.3 Responding to Cross-System Incidents/ Issues.....	13
11.4 ICB Collaboration	14
11.5 Timeframes for Patient Safety Incident Investigations (PSIIs) and Learning Responses.....	14
12. Safety Action Development and Monitoring Improvement.....	15
13. Safety Improvement Plans	15
14. Complaints & Appeals	16
Appendix A Governance, Audit and Monitoring and Equality Impact Assessment.....	16
Appendix B Equality Analysis - Impact Assessment Screening Tool.....	18

1. Introduction

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) published August 2022, updated September 2025 and sets out HUC's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have caused or cause did harm to one or more patients.

PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'Patient Safety Incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is not a different way of describing what came before it however fundamentally shifts how organisations providing NHS essential services responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate.

Instead, it:

- Advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- Embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management

This policy supports and promotes the four key aims of the PSIRF.

1. Compassionate engagement with patients, families, and staff affected by safety incidents.
2. System-based learning to improve safety culture and reduce harm.
3. Proportionate responses to incidents, ensuring appropriate action without unnecessary investigations.
4. Supportive oversight to strengthen governance, learning, and improvement efforts.

2. Scope

This PSIRF policy compliments HUC's overarching 'Incident Management Policy' which outlines the processes for identifying, reporting, investigating and learning from both patient safety and non-patient safety incidents and near misses.

This policy specifically defines roles and responsibilities related to patient safety incident responses undertaken solely for the purpose of learning and driving improvement across HUC.

Responses under this policy adopt a systems-based approach, enabling us to identify organisational risks related to patient safety and determine how best to address them. This approach supports HUC's commitment to continuous learning and improvement.

A systems-based approach recognises that healthcare operates within a complex environment made up of people, processes, tasks, equipment, and diverse care settings. These elements interact in dynamic ways, producing varying outcomes. By examining how these components work together across different situations, we gain a deeper understanding of the risks and challenges faced by patients and HUC colleagues. This insight allows us to identify more effective learning opportunities and implement improvements that enhance safety and the quality of care HUC provides.

When responding to incidents and safety events under PSIRF, there is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Other processes listed below (noting this may not be an exhaustive list), exist for this remit and are therefore outside of the scope of this policy:

- Litigation & Claims
- Investigations into employment concerns
- Professional standards investigations
- Safeguarding concerns
- HM Coronial Inquests and criminal investigations
- Complaints (except where a significant patient safety concern is highlighted)

Information from a patient safety response process can be shared with those leading other types of responses/ investigations, however, other processes should not influence the remit of a patient safety incident response.

Some patient safety incidents may also require a separate response that is not focused on learning for patient safety improvement. For example, some incidents where a patient dies may be subject to investigation by a Coroner to determine how, when and where the patient died. Others may involve the police where there is a reason to think criminal activity may have taken place. Some incidents may lead to concerns about an individual's fitness to practise or ability to do their job, and so may be considered by the employer or professional regulator.

Where a response is required that is not focused on learning for patient safety improvement, relevant referrals should be made to ensure it is conducted entirely separately. Care must be taken not to conflate and combine patient safety incident response activity with other remits.

HUC works in partnership with external stakeholders, system partners, NHS commissioners and colleagues to ensure meaningful investigation, learning and effective safety actions are taken across the patient journey.

This policy, alongside the organisations Incident Management Policy, supports the implementation and ongoing management of Patient Safety Incidents (PSIs) in line with the NHSE PSIRF standards ensuring compliance with a focus on:

1. Compassionate engagement with patients, families, and staff affected by patient safety incidents.
2. System-based learning to improve safety culture and reduce harm.

3. Proportionate responses to incidents, ensuring appropriate action without unnecessary investigations.
4. Supportive oversight to strengthen governance, learning, and improvement efforts.

3. Oversight roles and responsibilities

This policy reflects the principles set out in PSIRF and underpins the processes established to enable its effective implementation across HUC.

All colleagues are responsible for familiarising themselves with applicable HUC policies and adhering to the guidance provided.

Aligned with PSIRF's ethos, this policy supports the design and oversight of processes that promote continuous learning and improvement through patient safety incident responses. The focus is on demonstrating meaningful improvement rather than compliance with centrally mandated measures.

Roles and responsibilities, consistent with this policy and PSIRF principles, are defined as follows:

Patient Safety Specialist (PSS):

Patient Safety Specialists provide dynamic senior patient safety leadership. Each PSS provides expert support and has direct access to the executive team, which facilitates the escalation of patient safety issues or concerns.

The requirement for NHS organisations in England to identify one or more PSS as a key part of the NHS patient safety strategy and is included in the NHS standard contract. HUC's identified PSSs are:

- Chief Medical Officer
- Director of Quality and Nursing
- Deputy Chief Medical and Safety Officer
- Head of Nursing and Quality

PSS lead and support the local implementation of the NHS Patient Safety Strategy. They drive patient safety insight, involvement, and improvement activities, embedding systems thinking, human factors principles, and the ["Just & Learning Culture" Charter](#) into all processes.

PSS promote both understanding on why things go wrong and also why things go right. They support workforce training in line with the NHS patient safety syllabus, and collaborate across organisational, system, regional, and national networks to share learning and address safety issues.

They can also act as a local link for urgent national safety concerns when requested by NHS England.

Chief Medical Officer (CMO)

Holds executive accountability for PSIRF and HUC's Patient Safety Investigation Response Plan (PSIRP), ensuring the organisation has effective processes and systems in place to manage reported patient safety incidents, near misses, and wider clinical quality governance requirements, including the facilitation of Duty of Candour and shared learning.

Director of Nursing and Quality

Holds primary accountability for the organisation's Clinical Quality Governance processes, including PSIRF and PSIRP. Ensures fair, effective, and consistent processes for managing all levels of patient safety incident responses and investigations. Responsible for the completion of thorough, impartial investigations and reports, and liaises as required with governance teams in partner organisations and commissioning ICBs.

Deputy Chief Medical and Safety Officer

The Deputy Chief Medical and Safety Officer play a key leadership role in maintaining quality, performance, and a consistently high standard of patient care across the medical workforce. The postholder provides expert clinical input to executive decision-making on quality and safety, supporting the identification and mitigation of organisational risks. They actively promote a just culture and a psychologically safe environment in which clinicians feel confident to report concerns, while also recognising and celebrating good practice. Working closely with the Chief Medical Officer and executive team, the Deputy CMO supports the embedding of a safety-focused and innovative culture across all services, ensuring continuous learning and improvement in line with PSIRF principles.

Head of Nursing and Quality

Responsible for the day-to-day management of all patient safety incident and near-miss investigations, ensuring fair, effective, and consistent processes across all levels. Liaises as required with governance teams in partner organisations and commissioning ICBs.

Clinical Directors (CDs)

Holds day-to-day responsibility for clinical safety within their defined portfolio, including service-line patient incidents and near misses. Provides senior clinical oversight to ensure patient care remains central to all investigations and that actions are completed to mitigate risks and maintain safety.

Head of Allied Health Professionals (AHP)

The Head of AHPs provides day-to-day operational oversight of AHP services, ensuring safe staffing, high standards of care, and effective service delivery. The role supports quality and performance management, contributes professional expertise to patient safety and risk mitigation, and promotes a just, psychologically safe culture where staff feel able to raise concerns and learn.

Head of Safeguarding

Responsible for overseeing actions related to the safeguarding team in relation to patient safety standards following incident investigations. The Head of Safeguarding contributes to investigations by providing relevant knowledge, expertise, and experience as appropriate.

Clinical Quality & Governance Managers

Provide first-line support, advice, and guidance on the management of patient safety incidents and near misses across services, with responsibility for collating and overseeing patient safety data. The role monitors the timeliness of investigations and completion of safety actions to ensure learning is implemented. They also support or lead complex Patient Safety Incident Investigations (PSIIs), including gathering statements and service-level data, ensuring duty of candour requirements are met, preparing for panel meetings, and drafting investigation reports.

Operational Management Teams (Head of Service, Deputy Heads of Service)

Responsible for the oversight of all patient safety incidents and near misses within their services, ensuring those allocated are actioned appropriately with clear learning and safety actions developed. They are

responsible for ensuring that all colleagues working within their services are aware of and adhere to this policy (along with any future updates / amendments and work within the remit of this guidance.

4. Patient Safety Partners

Patient Safety Partners (PSPs) are a key component of the National Patient Safety Strategy, ensuring meaningful involvement of patients, carers, families, and lay representatives as partners in improving the quality and safety of NHS care.

PSPs play an important role within the Patient Safety Incident Response Framework (PSIRF) by bringing the patient perspective to investigations, responses, and learning, alongside those directly involved in incidents.

The appointment of PSPs provides an exciting opportunity for HUC to strengthen support for colleagues, patients, and families, and to influence improvements in quality and safety across our services. This role will evolve organically, fostering shared views, experiences, and perspectives from the community for the benefit of all involved in patient safety workstreams. The primary focus of PSPs is to amplify the voice of patients and the communities we serve.

Key Responsibilities of PSPs:

- Contribute proportional and objective feedback on selected written work, including policies, investigations, and reports.
- Participate, where appropriate, in service-level Clinical Quality Governance meetings and forums such as:
 - Safeguarding Assurance Group
 - Clinical Quality & Safety Committee (a subcommittee of the Board)

Support for PSPs:

- PSPs will be supported through guidance, reflective sessions, and supervision to ensure their wellbeing.
- Access to the organisation's Employee Assistance Programme (EAP) and HUC Academy training platform will be provided to ensure relevant training and development.

Duration of Appointment:

- PSP placements are honorary and will be reviewed after **two years** to ensure alignment with the evolving patient safety agenda.

5. Addressing Health Inequalities

HUC has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. We are committed to providing equitable opportunities for all individuals involved in patient safety incidents and ensuring effective engagement that considers diverse needs.

Through the implementation of PSIRF, we will use internal data and learning from investigations to identify actual and potential health inequalities and make recommendations to the HUC Board and partner agencies.

Data will be analysed to assess any disproportionate patient safety risks across protected characteristics, and these will be considered within every patient safety review.

Our engagement with patients, loved ones, families and carers following a patient safety investigation will be responsive to diverse needs. Any potential inclusivity or diversity issues will be identified during the investigation process, including the Duty of Candour (DOC) stage. All written communication will be drafted to ensure accessible to all, supported by the PSPs.

Equity, Diversity and Inclusion (EDI) remain a clear organisational priority. We operate a zero-tolerance approach to racism, discrimination, and unacceptable behaviours toward our colleagues, patients, carers, loved ones and families. These principles will be role-modelled by our Senior Leadership and Executive Teams; it will also underpin patient safety training and the system-based approach central to PSIRF best practice.

6. Our Approach to Incident Reporting and Learning

At HUC, we view all incidents and near misses as opportunities for learning and improvement. Reporting is encouraged and supported as a positive action. Colleagues are trained and empowered to report incidents confidently, knowing each will be investigated thoroughly in line with our Incident Management Policy.

We promote an open, honest, and blame-free culture, where safety actions are implemented to prevent recurrence and not utilised as punitive measures. Most incidents arise from system failures rather than individual actions; therefore, our focus is on identifying and addressing system issues to improve safety.

Our investigation and response processes are transparent, and learning is shared constructively at individual, team, and organisational levels. We emphasise that reporting volume or type is not a performance measure and the quality of the investigation and learning from it remains our priority.

Patients, families, loved ones and carers remain central to our approach. Where appropriate, they are involved under DOC, helping us to build trust in us and the services we provide.

We are committed to the NHS Resolution [“Just and Learning Culture Charter”](#) ensuring we provide psychological safety which encourages our colleagues to raise concerns and report incidents openly and without fear of reprisal.

In addition to incident and near-miss reporting, colleagues can access our [Freedom to Speak Up Guardian](#) which is provided independently by [The Guardian Service](#), the UK's leading confidential staff liaison provider. Further details are available in HUCs [Whistleblowing Policy](#).

7. Engaging and Involving Patients, Families and Colleagues Following a Patient Safety Incident

PSIRF recognises that meaningful learning and improvement following a patient safety incident depends on supportive systems and processes. It promotes a patient safety incident response approach that prioritises compassionate engagement and involvement with those affected, including patients, families, loved ones, carers, and colleagues. This involves working collaboratively to understand what happened and why, addressing any questions they may have, and signposting them to appropriate support where needed.

We are firmly committed to continuously improving the care and services we provide, learning from every incident where care does not go as planned or meet the expectations of patients, their families, or carers, in order to prevent recurrence. We recognise the significant impact patient safety incidents can have on all those affected and are committed to responding with openness, compassion, and sensitivity. Meaningful involvement of patients, families, and carers is central to how we respond to incidents and is essential to improving the quality and safety of our services.

7.1 Patients, Families and Carers

We recognise the significant impact patient safety incidents can have on patients, families, loved ones, and carers, and we are committed to continuously improving the care and services we provide.

Patients and families often bring invaluable perspectives to understanding incidents. As an organisation, we uphold candour by promoting openness, honesty, and transparency at all times. Full details of the Duty of Candour process and timeframes are outlined in the Incident Management Policy.

In summary, where moderate harm or above occurs due to an act or omission in care, patients or their families/loved ones receive a genuine, specific verbal apology within three days of being identified which is then followed up with appropriate written communication.

7.2 Communicating the Purpose of Patient Safety Investigations

When engaging with patients, families, loved ones, or carers, it is essential to clearly explain that the purpose of a patient safety incident response or investigation is to learn and improve, not to assign blame or initiate disciplinary action. This helps manage expectations and avoid misconceptions about regulatory or governing body involvement.

Further guidance on involving patients and families following a patient safety incident is available in [NHSE's resource: Engaging and involving patients, families and staff following a patient safety incident.](#)

7.3 Colleague Involvement & Support

Involving colleagues, including partner agencies, is essential to ensure a holistic and inclusive approach when responding to patient safety incidents.

Timely communication, clear guidance on the process, and access to support through peer networks, mental health first aiders, line management, the [Employee Assistance Programme \(EAP\)](#), and [free counselling via Spectrum](#) help ensure staff feel safe to contribute openly to learning. Additional support from Clinical Quality Governance Managers and Clinical Directors reinforces a focus on support, reflection, and continuous improvement rather than blame.

7.4 Measuring the impact of a positive patient safety culture

HUC will monitor the development of a positive safety culture using a range of qualitative and quantitative measures. These will include trends in patient safety incident reporting, the quality and timeliness of learning responses, staff engagement with incident reporting and learning activities, themes arising from Freedom to Speak Up (FTSU) contacts, staff survey results, patient feedback and complaints, and evidence that learning has led to sustainable improvements in practice.

Progress will be reviewed through HUC's governance reporting structures, led by the Clinical Quality and Safety Committee and supported by three key forums:

- **Safety and Compliance Forum** – oversees clinical compliance, clinician concerns, medical education, contract and CQC monitoring, clinical risk reviews, and digital innovation.
- **Quality and Audit Forum** – reviews learning from service-level clinical governance meetings, medicines management, audits, infection prevention and control, and service improvement projects, ensuring learning is translated into measurable improvements.
- **Patient Experience Forum** – considers learning from complaints, claims, safeguarding reviews, patient stories, surveys, and engagement activities to ensure the patient voice informs service development.

These governance arrangements provide oversight of patient safety learning, monitor the effectiveness of improvement actions, and ensure that learning is embedded across the organisation.

8. Patient Safety Incident Response Plan (PSIRP)

The PSIRP aligns with the principles of the Patient Safety Incident Response Framework (PSIRF), supporting the organisation to respond to incidents and safety issues in a way that prioritises learning and improvement rather than relying on arbitrary thresholds of harm. It enables a broader, more contextual approach to identifying patient safety incidents relevant to our services and the populations we serve, ensuring focus on those with the greatest potential for learning and improvement.

The PSIRP also incorporates wider sources of insight, including patient feedback, complaints, risks, legal claims, mortality reviews, and direct staff feedback, to provide a comprehensive understanding of safety. It is underpinned by thorough analysis of organisational data, collaborative stakeholder engagement, and a clear rationale for the response to each identified incident type. The plan is kept under regular review in response to emerging intelligence and improvement activity and is published on HUC's external website.

9. Resources and Training

PSIRF recognises that healthcare providers have limited resources and capacity to investigate and learn effectively from patient safety incidents. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan. The PSIRF provides more specific details in relation to this including the number of comprehensive investigations that may be required for single cases / patients or small groups of incidents that do not fall into one of the broader improvements workstreams/priorities.

The Chief Medical Officer, Director Quality, Nursing & IPC, Head of Nursing and Quality, Head of AHP, Clinical Directors and CQG Managers are all trained in line with the PSIRF requirements to complete learning responses.

All other colleagues will be required to complete mandatory patient safety training levels 1a which covers the basic requirements of reporting, investigating, and learning from incidents.

General	Course/Topic	Colleague group/Role	Training available	Provided by
NHS Patient Safety Syllabus	Level 1a - Essentials for all colleagues	All colleagues	e-LMS	NHS England
	Level 1b – For senior leaders and board members	Senior leaders and board members	e-LMS	NHS England
	Level 2 – Introduction to systems thinking and human factors	Colleagues undertaking learning responses	e-LMS	NHS England
PSIRF mandated	A Systems-based approach to investigating and learning from patient safety incidents	Investigation Leads	Online – self paced	HSSIB
	Oversight of learning from patient safety incidents	Investigation Leads	1 Day	External Provider

	Involving those affected by patient safety incidents in the learning process	Investigation Leads	1 Day	External Provider
Optional	Investigative interviewing	Investigation Leads	Online – 1 day	HSSIB

10. Our Patient Safety Incident Response Plan (PSIRP)

Our plan outlines how we will respond to patient safety incidents over a 12 to 18 month period. It is a flexible framework, not a fixed set of rules or trigger points. Each response will consider the specific circumstances of the incident and the needs of those affected, while aligning with the principles of the plan.

10.1 Review of our Patient Safety Incident Response Policy & Plan

Our Patient Safety Incident Response Plan is a live working document that will be updated as needed to reflect learning and changes in our patient safety profile. The plan will be formally reviewed every 12–18 months to ensure it remains current and effective. This review will also provide an opportunity to re-engage stakeholders and agree on any changes.

Updated versions will be published on our website, replacing previous editions. In addition, a comprehensive review will be undertaken every three years (or sooner if agreed with Hertfordshire ICB) to ensure a balanced focus on learning and improvement. This review will include:

- Assessment of response capacity and service mapping
- Analysis of organisational data (e.g., PSII reports, improvement plans, complaints, claims, staff surveys, inequalities data)
- Wider stakeholder engagement

11. Responding to Patient Safety Incidents

11.1 Patient Safety Incident Reporting Arrangements

Patient safety incident reporting will remain in line with HUC's Incident Management Policy. All incidents and near misses are reported via our Incident Management System (IMS), RADAR.

It is recognised that colleagues must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement in line with the [“Just & Learning Culture” charter](#).

11.2 Patient Safety Incident Response Decision-Making

We have clinical quality governance and assurance systems to ensure oversight of incidents and near misses across the organisation. Clinical Governance managers work closely with the Service Line Heads of Departments and Clinical Directors to ensure the following arrangements are met.

There are processes in place to communicate with and escalate any appropriate incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements, to include, but not limited to:

- Identification and escalation of any incidents that have, or may have caused moderate or serious harm, or death
- Identification of themes, trends, or clusters of incidents / near misses within a specific service
- Identification of any incidents / near misses relating to local risks and issues (e.g., CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (e.g., Never Events & RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

PSIRF itself does not define rules or thresholds to determine what method of response should be used to support learning and improvement. We have developed our own response process to facilitate the balance between robust and proportionate responses.

Daily safety huddles provide a structured and consistent forum to identify, discuss, and review any incidents where potential or actual harm may have occurred, supporting early recognition of risk and prompt consideration of immediate actions required to keep patients safe.

Where concerns require further exploration, cases are escalated to a weekly Rapid Review Decision Meeting (RRDM) chaired by the Chief Medical Officer or Deputy Chief Medical Officer, with multidisciplinary representation including clinical teams, clinical governance, safeguarding, and patient experience. This group collectively assesses the information available, determines the level of response required, and agrees whether a formal investigation or additional review is necessary.

Where indicated, further investigation is undertaken with input from those directly involved in the incident, alongside relevant subject matter experts, to ensure a fair, thorough, and well-rounded understanding of events that supports meaningful learning and improvement.

Learning responses may include a range of proportionate approaches depending on the nature and complexity of the incident, including a local incident review, After Action Review (AAR), Thematic Review (TR), HM Coroners or Solicitors Report or a response letter to a Patient Complaint. These approaches ensure that learning is captured at the appropriate level, shared effectively across teams, and used to inform wider service improvement and patient safety initiatives.

11.3 Responding to Cross-System Incidents/ Issues

We are committed to nurturing positive relationships with partner providers and our ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system patient safety incidents. We recognise that, in some instances, it will be appropriate for us to work in partnership with other providers, such as acute trusts, ambulance trusts or GP practices.

The Clinical Quality and Governance team will ensure any incidents or near misses that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required. We will reciprocate and fully engage in a proportionate and meaningful way to cases led externally to HUC.

Upon identification that a patient safety incident has occurred within a service that is managed in partnership with HUC, or by a separate provider, the clinical quality and governance team will be the initial and primary contact / liaison point, with supportive operating procedures to ensure that this is effectively managed.

11.4 ICB Collaboration

We are fortunate to have effective and trusted working relationships with all our commissioning ICBs.

Where appropriate, a learning summary will be shared with the relevant ICB; we will reach out to request support, as required, for any specific PSIs if/when additional or external scrutiny is deemed to be appropriate, to ensure proportionate involvement from the ICBs, recognising their own resource and capacity limitations.

For complex cases, such as multi-touchpoint provider incidents that span across the system, we will defer to the relevant ICB for co-ordination in identifying a suitable lead reviewer in such circumstances.

Learning response and actions developed will flow through our internal assurance processes and reporting structures in addition to those of our provider colleagues and any recommendations made by the ICB. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

PSIs and the PSIRP updates will be shared as appropriate at the Contract and Quality monitoring meetings.

11.5 Timeframes for Patient Safety Incident Investigations (PSIs) and Learning Responses

There are no fixed time limits for completing PSIs; however, best practice recommends starting investigations as soon as possible after the incident is identified and completing them within 1–3 months. Where an independent investigator is commissioned, a timeframe of up to 6 months is typically allowed.

Timeframes must be clearly communicated to patients, families, loved ones, and carers. Any delays should be shared promptly with an explanation and revised completion date. Where external processes or partner organisations cause delays, decisions will be made on whether to pause or progress the investigation, with further activity considered if new information emerges.

Learning responses must balance timeliness with thoroughness, capturing information while details remain fresh. The timeframe for completion should be agreed with those affected, where possible, and no local PSI should exceed 6 months.

Indicative timeframes for learning responses:

- Initial incident review: within 3 working days of reporting
- Further learning response: within 30 working days of reporting

Different tools and response types will be used based on the circumstances of the incident. Guidance and templates are available in the Incident Management Policy and via the [NHSE toolkit](#).

12. Safety Action Development and Monitoring Improvement

Safety actions will be developed in collaboration with the service where the incident occurred and be based on the recommendations of the investigators. The actions are signed off by the Clinical Director and Operational Director for the service and tracked via monthly action tracking meetings.

All actions should be Specific, Measurable, Achievable, Relevant and Time-bound (SMART). Guidance from NHSE (PSIRF) for the development of actions is provided to investigators. Progress of actions will also be submitted to the Clinical Quality and Safety Committee (CQSC).

The CQSC has delegated responsibility for oversight of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

13. Safety Improvement Plans

Our Patient Safety Incident Response Plan (PSIRP) sets out how we will investigate patient safety incidents and themes holistically and inclusively, focusing on local priority areas to identify learning and implement safety actions that reduce risk and improve outcomes.

Safety Improvement Plans (SIPs) consolidate findings from investigations and may take different forms:

- Organisation-wide SIPs for learning that spans services or locations
- Service-specific SIPs for targeted improvements
- Plans addressing single incidents where systemic issues are identified
- Plans for broad system improvements

The rationale for each approach will be documented and agreed with stakeholders.

Priority areas in our PSIRP were identified through analysis of internal data (incidents, audits, complaints, feedback, risk register, and soft intelligence) to strengthen insight into our safety profile. These priorities aim to reduce harm and improve patient experience:

1. Learning disabilities
2. Breathing difficulties
3. Delays
4. Palliative care

Learning will inform safety actions and SIPs, with progress monitored through the CQSC.

14. Complaints & Appeals

We recognise that patients, service users, or carers may occasionally be dissatisfied with aspects of care. Concerns about this guidance or its implementation can be raised informally with the Head of Quality, Nursing & IPC, who will seek local resolution where appropriate.

It is important to distinguish between concerns and complaints. A complaint is a formal expression of dissatisfaction requiring review, as defined in our [Complaint Management Policy](#). The first point of contact for a formal complaint is the Head of Patient Experience, who will provide support and oversee the process.

Complaints are addressed promptly and respectfully, ensuring all parties feel involved and informed. Lessons learned from complaints are used positively to improve services.

Contact for formal complaints:

- **Website:** www.hucweb.co.uk/contact
- **Email:** huc.feedback@nhs.net
- **Phone:** 0808 260 9934
- **Post:** Patient Experience Team, HUC, The Old Ambulance Station, Ascots Lane
, Welwyn Garden City, AL7 4HL

Appendix A Governance, Audit and Monitoring and Equality Impact Assessment

Governance	
Definitions <i>Any Acronyms or Abbreviations used in policy</i>	PSIRF – Patient Safety Incident Response Framework ICB – Integrated Care Board PSP – Patient Safety Partners NHSE – National Health Service England PSIRP – Patient Safety Incident Response Plan HSSIB – Health Services Safety Investigations Board CQC – Care Quality Commissioner RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations SMART - Specific, Measurable, Achievable, Realistic, Time-bound PSII – Patient Safety Incident Investigation AAR – After Action Review
Related Policies <i>Any policies or guidelines that directly impact or are impacted by this policy</i>	• Patient Safety Incident Response Plan • S6 Incident Management Policy • C3 Concerns and Complaint Policy • W1 Whistleblowing Policy • S2 Adult Safeguarding Policy • S3 Children Safeguarding Policy • I6 Information Governance Policy • I5 IT and Network Security Policy • HS1 Health and Safety Policy

References <i>e.g... NICE guidance, externally recognised reports or research</i>	• NHS Just & Learning Culture Charter • NHSE Guidance – Engaging and involving patients, families and staff following a patient safety incident • Patient safety learning response toolkit • Safety action development guide
Search terms Put in key word search terms,	Patient Safety, Incident, PSIRF
Circulation/ Training <i>How are you going to ensure that colleagues know about the document and are trained in its use</i>	The policy will be added to the weekly HUC communications newsletter. All colleagues involved in Incident investigation including Patient Safety Incidents will be signposted to this document Support and advice is available from the Clinical Governance team
Impact Assessment	
Equality and Diversity	The requirement for Equality Analysis Impact Assessment of all changes to policy, strategy or process has been added to this Policy including mention of the need to consider the application of the NHS Accessible Information Standard. Additionally, the Equality Analysis Impact Assessment Screening Tool for Policies has been applied to this policy to ensure consideration of fair treatment, access, inclusion and health inequalities, and the requirement that any evidence or factor being identified which affects one group more or less favourably than another is addressed.
Business	
Legal Implications	The use of standardised procedures should reduce the risk of legal action
Quality	The use of standardised procedures should ensure that quality is maintained
Resources	Colleagues will understand the policy process
Risk	The use of standardised process should ensure compliance with CQC regulations
Statutory Compliance	
Sustainability	The use of the intranet and other electronic systems will reduce paper used within HUC

Monitoring / Audit Criteria

What is the standard / audit criteria	Monitoring method	Responsibility for monitoring	Timeframe	Reported to:
Ensure that policies and guidelines are all within date	Reminders to Authors	Corporate & Clinical Quality Governance team	Monthly	
Review of out-of-date documents	Monthly report	Corporate & Clinical Quality Governance team	Monthly	

Appendix B Equality Analysis - Impact Assessment Screening Tool

AREA	NEGATIVE IMPACT		SIGNIFICANT Y/N?	
	Y ✓	N ✕	Y ✓	N ✕
1. Gender		N ✕		N ✕
2. Religion/ belief		N ✕		N ✕
3. Age		N ✕		N ✕
4. Disability (includes: mental health, learning disability, physical, sensory)		N ✕		N ✕
5. Ethnicity (includes: travellers and gypsies)		N ✕		N ✕
6. Sexual Orientation (includes: gay, lesbian, bisexual)		N ✕		N ✕
7. Transgender / Tran-sexual		N ✕		N ✕
8. Marriage or Civil Partnership		N ✕		N ✕
9. Pregnancy or Maternity		N ✕		N ✕
Additionally		N ✕		N ✕
10. Social / Economic		N ✕		N ✕
11. Rural / Urban		N ✕		N ✕
12. Health Inequalities		N ✕		N ✕
13. Application of NHS Accessible Information Standard		N ✕		N ✕

Appendix 1. Incident management flow chart

